OFFICE OF INSURANCE FRAUD PROSECUTOR

March 1, 2000

ANNUAL REPORT 1999

NJ Department of Law & Public Safety
Division of Criminal Justice
Office of Insurance Fraud Prosecutor

IN MEMORIAM

On December 17, 1999, the Office of Insurance Fraud Prosecutor suffered an unexpected and tragic loss when Thomas J. Kiselica, Deputy Chief Investigator in charge of civil investigations, passed away. His intelligence, compassion, organizational skills, grace, sense of fairness and hard work contributed much to the establishment of this Office and his leadership is and will be deeply missed. This report, reflecting much of the work he completed, is dedicated to his memory.

State of New Jersey
DEPARTMENT OF LAW AND PUBLIC SAFETY
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CHRISTINE TODD WHITMAN
Governor

JOHN J. FARMER, JR.
Attorney General

February 29, 2000

Honorable Christine Todd Whitman
Members of the New Jersey Legislature
State House
Trenton, New Jersey 08625

Re: Annual Report of the Office of Insurance Fraud Prosecutor

Dear Governor Whitman and Members of the Legislature:

We are pleased to provide you this first Annual Report by the Office of Insurance Fraud Prosecutor (OIFP).

The report includes investigative and prosecutorial statistics, as well as summaries of significant cases, and describes the efforts to combat fraud which have been undertaken by OIFP during 1999. As you know, OIFP has now completed its first full calendar year of operation. During that time, we believe that OIFP has made great progress toward fulfilling its mission of conducting full and fair investigations and in broadcasting its message of deterrence through both education and vigorous prosecution.

Respectfully submitted,

John J. Farmer, Jr.
Attorney General

Edward M. Neafsey
Prosecutor

ANNUAL REPORT

OF THE

OFFICE OF INSURANCE FRAUD PROSECUTOR

For Calendar Year 1999

Pursuant to N.J.S.A. 17:33A-24d

March 1, 2000

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ACKNOWLEDGMENTS

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The Prosecutor would also like to thank all members of the Office of Insurance Fraud Prosecutor for their outstanding work during OIFP's first calendar year of operation. The number and significance of OIFP's criminal prosecutions provided national recognition for OIFP in this short time. The quality of the civil investigations conducted and the amount of monies collected pursuant to consent orders have served to define the credibility and excellence of OIFP. The commitment and professionalism of each member of OIFP is hereby acknowledged with pride and gratitude.

PREFACE

The Office of Insurance Fraud Prosecutor was created by the Legislature on May 19, 1998, as part of the Automobile Insurance Cost Reduction Act (AICRA). *P.L.* 1998, *c.* 21. As indicated in the legislative statement accompanying AICRA, OIFP was created to "provide for a more effective investigation and prosecution of fraud than exists at the present time." OIFP is situated within the Division of Criminal Justice in the Department of Law and Public Safety and is headed by the Insurance Fraud Prosecutor. The Prosecutor, who is appointed by the Governor and approved by the Senate, reports to the Attorney General. *N.J.S.A.* 17:33A-16.

Creation of OIFP required certain civil enforcement functions, which were previously the responsibility of the Department of Banking and Insurance, to be transferred to OIFP through the vehicle of a Reorganization Plan, which was effective on August 24, 1998. *Reorganization Plan* No. 007-1998. On October 28, 1998, Edward M. Neafsey was sworn in as New Jersey's first Insurance Fraud Prosecutor.

Under AICRA, OIFP is charged with investigating all types of insurance fraud and serves as the focal point for all criminal, civil and administrative prosecutions of insurance and Medicaid fraud. OIFP is additionally charged with responsibility for coordinating all insurance-fraud related anti-fraud activities of State and local departments and agencies in order to enhance the State's fully integrated law enforcement system.

Pursuant to *N.J.S.A.* 17:33A-24d, an annual report to the Governor and Legislature is to be made by March 1 of each year as to the activities of the Insurance Fraud Prosecutor during the previous calendar year. The following constitutes the Annual Report of OIFP for calendar year 1999, the first full year of its existence.

STATEMENT OF THE PROSECUTOR

One year ago, although the Office of Insurance Fraud Prosecutor had been in existence only a few months, we provided an Initial Report to the Governor and Legislature documenting the efforts undertaken in setting up OIFP and some of its early accomplishments. At that time I stated that one of the chief missions of OIFP would be to target practitioners who submit false insurance claims to private or government providers and, in accordance with the legislative intent indicated in the establishment of OIFP, emphasize criminal investigation and prosecution, because I believe that to be one of the most effective ways to deter the white collar crimes of insurance and Medicaid fraud. This past year has largely demonstrated the accomplishment of that goal. Furthermore, through our public awareness campaign, through our civil enforcement actions, through our seeking revocation of professional licenses and through our criminal prosecutions, OIFP is spreading the message that insurance fraud is not a victimless crime, but rather is an economic crime adversely impacting all law-abiding citizens. We will continue to send that message by fully investigating referrals, aggressively prosecuting violators and seeking appropriate sanctions.

During this past year, I have spoken to numerous consumer, legal, industry and law enforcement groups about the creation and work of OIFP. Additionally in 1999, OIFP fraud prosecutions netted an aggregate of more than 50 years of incarceration against 16 defendants, an unprecedented record year for jail sentences in New Jersey for these white collar crimes, and a level of success which I believe achieves its intended deterrent effect on those who might otherwise consider insurance and Medicaid fraud an easy way to make a "quick buck." As I look forward to OIFP's efforts in 2000, I believe greater emphasis will be placed on large scale, complex investigations. Because these investigations cannot reasonably be expected to be completed within a calendar year, OIFP may see a change from its 1999 numbers. Nevertheless, OIFP's effort will remain focused on making large impact cases, while simultaneously prosecuting smaller cases to maintain our message of deterrence in the public eye.

OIFP has now completed its first calendar year of operation. I begin this report with a brief summary of some of the case highlights which occurred during 1999.

Edward M. Neafsey
Prosecutor

CASE HIGHLIGHTS

During 1999, OIFP opened 344 new criminal investigations of insurance or Medicaid fraud. During this same period, in 87 prosecutions, charges against 134 defendants were lodged by indictment or accusation. Criminal prosecutors obtained 78 convictions in 1999, with 16 of those defendants, or approximately one in five, receiving jail, aggregating more than 50 years of incarceration, as part of their sentence:

CRIMINAL PROSECUTORS OBTAINED 78 CONVICTIONS IN 1999, WITH APPROXIMATELY ONE IN FIVE RECEIVING JAIL.

Defendants Receiving Jail Time (1999)			
Dr. Jayen Shah	Jan. 7, 1999	disability insurance fraud	5 years
Ronald Cavigliano	Feb. 26, 1999	auto "give up" insurance fraud	8 years
Mohammad Javid	Feb. 26, 1999	false Medicaid claims by blood lab	10 years
Tahir Sherani	April 1, 1999	false Medicaid claims by blood lab	364 days
Rehan Zuberi	April 30, 1999	false Medicaid claims by blood lab	6 years
Leonid Giller	June 4, 1999	Medicaid transportation fraud	90 days
Felix Zak	June 4, 1999	Medicaid transportation fraud	90 days
Karen Lawder	June 4, 1999	Health Care Claims Fraud (1st prosecution)	3 years
Allen Kearney	Aug. 11, 1999	health insurance fraud (*Lichtman* co-defendant)	90 days
Hani Elias	Aug. 20, 1999	fake insurance i.d. cards	364 days
Ernest Woodson	Sept. 9, 1999	Health Care Claims Fraud ("slip & fall")	364 days
Sharon DaCosta-Barrett	Sept. 10, 1999	theft by Blue Cross/Blue Shield employee	4 years
Susan Malady	Nov. 5, 1999	theft from hospital by nurse	5 years
Jack Chesner	Dec. 7, 1999	attempted property insurance fraud	4 years
Vivian DeCree	Dec. 9, 1999	health insurance fraud (*Lichtman* co-defendant)	5 years
Dr. Lawrence Nessman	Dec. 15, 1999	health insurance and PIP fraud	364 days
TOTAL			**54 3/4 YEARS**

In seeking to effectuate its legislative responsibility to coordinate all insurance-related anti-fraud activities, OIFP has strived to create effective communication and cooperation with other agencies, whether federal, state or local, and whether law enforcement, private or governmental, which have an interest in combating insurance fraud. A number of the criminal prosecutions conducted by OIFP were made possible or enhanced by cooperative efforts with other agencies. Many of the investigations being conducted by OIFP, of course, have not yet resulted in prosecution in court or proceeded to the point of criminal conviction and sentencing. Nevertheless, in its first full year of operation, OIFP has made significant strides in making its law enforcement presence known and in publicizing the fact that insurance and Medicaid fraud are serious crimes. The following is a brief summary of some of the more significant prosecutions, civil and criminal, of calendar year 1999.

HEALTH CARE CLAIMS FRAUD

Fraud by Licensed Professionals

State v. Karen A. Lawder, L.C.S.W. On June 4, 1999, in the first case prosecuted under the new Health Care Claims Fraud Act, Lawder received a three year State prison sentence for submitting $4,000 in bogus personal medical bills to Blue Cross/Blue Shield. Lawder, a school counselor and licensed clinical social worker, falsified claim forms and invoices which she submitted to her health insurance plan seeking reimbursement for personal counseling sessions which she neither attended nor paid for. Lawder also paid $6,440 in restitution to Blue Cross/Blue Shield. Following OIFP's referral of her criminal conviction to the New Jersey Board of Social Work Examiners, Lawder's professional license was revoked. Because the participation of licensed professionals in insurance fraud cannot be tolerated, and because such persons, having much to lose from detection, may be more readily deterred from committing such white collar crimes, OIFP, with the goal of general deterrence in mind, seeks tough criminal and licensing sanctions when insurance fraud is committed by a licensed professional.

THE PARTICIPATION OF LICENSED PROFESSIONALS IN INSURANCE FRAUD CANNOT BE TOLERATED.

State v. Carl Lichtman, et al. As reported in OIFP's Initial Report last year, on February 2, 1999, one of the largest insurance fraud and public corruption prosecutions in State history advanced significantly with the return of 37 indictments charging 65 people with having conspired with former psychologist Carl Lichtman to defraud the State Health Benefits Plan and other health insurers of $3.5 million for no show treatments for "neurotic depression." Lichtman pocketed the money for the bogus treatments and kicked back 25%

to those persons who had provided their insurance information to him. Lichtman also paid "referral fees" to those who brought new individuals into the conspiracy. Lichtman had enlisted approximately 200 other persons, many of whom were public employees, to provide health insurance information to him so that he could bill 35 insurance carriers or other insurance plans for treatments which were never rendered. At the close of 1999, more than 150 of these individuals have already pleaded guilty to the charges, including ***Allen Kearney***, who, on August 11, 1999, was sentenced to serve 90 days in jail, pay $2,312.50 in restitution and a $5,000 civil penalty for his participation in the scheme. In addition, to date, the Lichtman co-defendants entered 151 civil consent orders under which they were required to pay $513,540 in civil penalties.

On September 30, 1999, ***Vivian Decree***, a crossing guard who was the first of the indicted defendants to go to trial, was found guilty of all charges. She was sentenced on December 10, 1999, to five years in prison and ordered to pay $1,900 in restitution and a $3,000 fine. On November 16, 1999, ***Kevin Spencer***, a former cook for the Newark Board of Education, pleaded guilty to charges of theft by deception and conspiracy for his role in this fraud scheme. Spencer had taken an active role in the scheme by bringing other people into the scam and taking kickbacks for those referrals. At his sentencing on February 18, 2000, Spencer received a three year prison sentence and was required to pay a fine of $10,000 and restitution of $11,094. Because Spencer's sentence was imposed in 2000, it is not, however, included in the statistical summaries of this report. Cases against the remaining co-defendants are pending in court.

DECREE WAS SENTENCED TO FIVE YEARS IN PRISON.

Newcomb Medical Center. On February 11, 1999, OIFP entered into a civil settlement with Newcomb Medical Center whereby Newcomb would pay approximately $2,700,000 to the State. On March 2, 1999, Newcomb Medical Center paid the State $1,796.691.06, and on July 28, 1999, Newcomb paid the remaining $1,000,000 to the State in satisfaction of the civil settlement agreement. The civil matter arose in connection with an indictment against the ***Excel Center, Inc.***, a Newcomb Medical Center outpatient drug and alcohol affiliate, and Excel's executive director, ***Tommie Murry, Jr.*** Excel and Murry were charged with billing the Medicaid program, through the hospital, for more than $500,000 in counseling services not rendered to patients. The criminal case against Murry and Excel is pending in court.

State v. Yogendra Sharma. On December 9, 1999, a licensed Trenton optician pleaded guilty to health care claims fraud in billing for approximately $3,000 in services never rendered to Medicaid recipients. At his sentencing, which occurred on February 8, 2000, Sharma received a fine of $12,000, lost his professional license for one year, was debarred from the Medicaid program and was required to pay full restitution. From January 1998 through May 1999, Sharma had billed Medicaid for UV coatings and tint on eyeglasses, although such services were never authorized in any prescriptions, and Sharma failed to actually provide the UV coating or tint for more than half of the patients for whom bills were submitted to Medicaid.

State v. Richard Herbert, et al. On December 10, 1999, an East Orange chiropractor was

arrested on multiple counts of health care claims fraud and illegally obtaining prescription drugs. The chiropractor, and two of his former staff employees who were arrested on December 16, 1999, are charged with health care claims fraud for allegedly submitting between October 1998 and September 1999 more than $4,000 in insurance claims for patient services which were never rendered. Herbert was also charged with possession of a controlled dangerous substance (CDS) without a prescription for allegedly obtaining approximately 50 drugs from an East Orange pharmacy within a ten month period. He was also charged with obtaining CDS by fraud for reportedly misrepresenting himself while procuring the drugs. This criminal investigation is ongoing.

State v. John Amabile. On August 10, 1999, a State Grand Jury indicted Amabile, a formerly licensed optometrist from Monmouth County, on charges of attempting to defraud 29 insurance carriers and health benefits plans of more than $200,000 by submitting false health insurance claims. The indictment alleges that Amabile attracted large numbers of patients to his offices by offering routine eye exams and glasses at little or no cost, and then used the patients' insurance information to bill their carriers for optometric services which he had not provided. Amabile is charged with directing his staff to make false entries in the optometric charts of 997 patients in order to falsely document his insurance billings in the event the claims were questioned. Amabile's license to practice optometry has been revoked by the State Board of Optometrists and a $1.1 million civil penalty has already been imposed. The criminal charges are pending in court.

AMABILE IS CHARGED WITH DIRECTING HIS STAFF TO MAKE FALSE ENTRIES IN THE OPTOMETRIC CHARTS OF PATIENTS IN ORDER TO FALSELY DOCUMENT HIS INSURANCE BILLINGS IN THE EVENT THE CLAIMS WERE QUESTIONED.

State v. Mario Macias, et al. On September 14, 1999, a former corporate officer and manager of three defunct medical providers was indicted for defrauding 11 insurance carriers of more than $85,000. According to the indictment, over a period of four years, the medical providers, under Macias' direction, failed to render medical services or provide equipment, but billed several health insurers as if they had. It is alleged that, between May 1991 and March 1995, Macias and The Healing Clinic, Inc., a physical therapy and chiropractic facility, submitted approximately 88 false health insurance claims to insurers, and that Macias and Hudson Neurological, Inc., a neurological testing facility, also submitted 53 false insurance claims for testing which was not actually performed. In addition, Florida Medical Supply, Inc., submitted approximately 21 false health insurance claims for medical equipment which was not actually provided. The case is pending in court.

State v. Nitin Khandwala. On September 21, 1999, a licensed Elizabeth pharmacist pleaded guilty to an accusation charging him with third degree Medicaid fraud. The accusation charges that Khandwala submitted false purchase invoices to auditors from the State Medicaid agency to support billings he had previously submitted for an expensive medication. During 1998, the pharmacy had obtained payment of approximately $10,000 for medications it had never dispensed or even maintained in its inventory. When, approximately a year later, auditors from the State requested Khandwala to substantiate his

purchase of the medication, he submitted a false invoice which he had secured from one of his regular suppliers. Khandwala, who made full restitution to the Medicaid program, was sentenced on November 5, 1999 to five years probation, a $10,000 fine and 500 hours of community service. The investigation was referred to OIFP by the Division of Medical Assistance and Health Services, Bureau of Program Integrity in the Department of Human Services upon their uncovering the apparent fraud. The matter has been referred to the appropriate professional licensing board for disciplinary action.

State v. Family Enrichment Institute, et al. On December 7, 1999, the Family Enrichment Institute, a drug and alcohol center, its clinical director, executive director and two employees were indicted on charges of filing false Medicaid claims. This case, the first Medicaid fraud indictment under the Health Care Claims Fraud Act, resulted from an OIFP undercover operation in which three State Investigators went to the clinic to seek counseling services, but each attended only the initial evaluative session. The clinic thereafter submitted bills to Medicaid for an additional 14 visits which never occurred. The investigation identified an additional 1,178 false claims on other Medicaid recipients, including eight submitted for treatment after the death of a patient. Because three of the defendants are licensed social workers, the matter will also be referred to the appropriate professional licensing board.

THE FIRST MEDICAID FRAUD INDICTMENT UNDER THE NEW HEALTH CARE CLAIMS FRAUD ACT RESULTED FROM AN OIFP UNDERCOVER OPERATION.

State v. Dr. Lawrence Nessman. On December 16, 1999, Nessman, who had pleaded guilty on July 7, 1999, to second degree theft and attempted theft by deception, was sentenced to serve 364 days in county jail as a condition of his five year term of probation. Nessman, formerly a licensed, osteopathic physician, was also required to permanently surrender his license to practice medicine, pay $213,000 in restitution and a $100,000 civil consent judgment. Nessman, who is currently in poor health, was charged with having obtained $213,000 from various health and auto insurance carriers by submitting claims which falsely indicated that he had performed osteopathic procedures which were not in fact rendered. According to the plea, Nessman sent bills for personally treating patients on dates when he was not in the State.

State v. United Diagnostic Laboratories, et al. Three members of a Medicaid fraud money laundering scheme were sentenced to jail terms during 1999. On February 26, 1999, ***Mohammad Javid*** was sentenced to ten years in jail for his role as the leader of the scheme. On April 1, 1999, and April 30, 1999, ***Tahir Sherani***, who was convicted in a jury trial, and ***Rehan Zuberi***, respectively, received jail terms of 364 days and six years. Javid operated a blood laboratory and paid kickbacks to clinic operators Sherani and Zuberi to induce them to refer blood specimens to his lab for fraudulent and expensive tests. The clinics' patients were Medicaid recipients who were generally unaware that their blood was being subjected to a battery of unnecessary tests. To hide the

JAVID WAS SENTENCED TO TEN YEARS IN JAIL.

money, the defendants set up "shell companies" to receive the kickbacks and launder the money stolen from the Medicaid program. All the defendants were debarred from the Medicaid program.

State v. Henry Heller. On November 24, 1999, attorneys in the Division of Law obtained a default judgment in the amount of $50,000 against Heller, a former pharmacy employee. Heller submitted to his insurance company approximately 110 phony prescription receipts and 18 forged certifications verifying that the prescriptions were allegedly dispensed.

"Bust Out" Scheme

State v. Mohammed Haider. On September 13, 1999, the former owner of a Paterson medical clinic was indicted by a State Grand Jury for bilking Medicaid of more than $450,000 for health care tests which were never performed. The clinic owner was charged with having submitted more than 5,600 separate, fraudulent billings for costly sonogram and MRI testing to the Medicaid program for what appears to be a typical "bust out" scheme, in which a shell company is opened for the sole purpose of committing fraud and can be abandoned if discovered. The indictment alleges that the fraudulent Medicaid billing practices spanned the entire time the clinic operated, from July 1996 through October 1997, during which time claims for tests which were not done and for which the clinic did not have equipment were submitted for payment. According to the charges, many of the Medicaid recipients whose accounts were billed for sonogram and MRI testing denied having had those tests conducted and others denied ever having gone to Haider's clinic. After learning that his operation was under investigation, Haider closed the clinic and absconded. OIFP caused a warrant to be issued for Haider's arrest.

"Slip and Fall"

State v. Ernest Woodson. On October 15, 1999, Woodson, a South Jersey man with seven aliases, was sentenced to 364 days in jail for having made 21 false insurance claims for slip and fall accidents at 19 stores. For example, on June 17, 1998, Woodson claimed he fell at a Wawa store in Vineland and injured his hip and damaged his glasses. This claim was settled with the insurer for the store for under $1,000. On July 7, 1998, Woodson told store personnel at a Rite Aid drug store in Vineland that he had fallen on their premises,

OIFP'S INTEREST IN DETERRENCE LEADS IT TO TARGET SMALLER FRAUD CASES AS WELL AS THE LARGE-SCALE ORGANIZED RING CASES.

breaking a tooth and damaging his glasses. His claim was settled for over $4,000. On September 4, 1998, Woodson claimed that he fell at a Thriftway store in Bridgeton, injuring his left knee and, again, damaging his glasses. He received $1,000 to settle his claim. This prosecution illustrates that OIFP's interest in deterrence leads it to target smaller fraud cases as well as the large-scale organized ring cases. The Woodson case was initiated by OIFP - Civil, when civil investigators, during a regularly attended liaison meeting with industry, were approached by an SIU investigator who related that he had information regarding Woodson's committing multiple slip and falls. The civil investigators conducted a preliminary investigation of the case with the SIU and determined the information to be credible. The matter was then referred to OIFP-Criminal for completion of the investigation and prosecution.

Medicaid Equipment Fraud

State v. Vicki Poh-Eikom. On August 31, 1999, Poh-Eikom, the president of a now-defunct durable medical equipment supplier, Sun Rehab, Inc., pleaded guilty to one count of Medicaid fraud and was sentenced to a three year term of probation on condition that she pay restitution of $16,470 and a fine of $2,500. She was also debarred from the Medicaid program. Poh-Eikom, who was indicted in April 1999, was charged with receiving payment for equipment that was never delivered to the patients for whom it was billed, despite Poh-Eikom having certified in invoices submitted to Medicaid that the equipment had been delivered.

Medicaid Transportation Fraud

State v. Felix Zak, et al. On June 4, 1999, Zak and Leonid Giller, owners of F&L Medical Transportation Company, received sentences of probation with the requirement that they serve 90 days in county jail and pay $78,584 in restitution and civil penalties, as well as a $1,000 criminal fine on third degree Medicaid fraud charges. Both defendants were additionally debarred from the Medicaid program. OIFP investigators discovered what appeared to be excessive mileage billings for transportation services being submitted to the Medicaid program by F&L, in that F&L transported most of its patients in a confined geographical area in Union and Middlesex Counties.

State v. Genady Chulak, et al. On August 26, 1999, Medicall, an invalid coach transportation company, and its owners were indicted for defrauding the Medicall program of more than $500,000. Following up on an anonymous tip that Medicall was inflating mileage charges to the Medicaid program, OIFP investigators' surveillance of Medicall vans resulted in a comparison of distances actually driven to those claims later submitted to the Medicaid program which revealed that Medicall was grossly inflating mileage charges. During execution of a search warrant at Medicall's office, ten $95,000 certificates of deposit in the defendants' names were found and are the subject of a related forfeiture complaint.

DURING EXECUTION OF A SEARCH WARRANT, TEN $95,000 CERTIFICATES OF DEPOSIT IN THE DEFENDANTS' NAMES WERE FOUND AND ARE THE SUBJECT OF A CIVIL FORFEITURE COMPLAINT.

AUTO INSURANCE FRAUD

Staged Accidents

State v. Anhuar Bandy, et al. In July 1999, ten people were arrested and search warrants executed at eight chiropractic clinics and medical offices across northern New Jersey. Arrest warrants were obtained for two additional defendants who remain fugitives. The complaints charge Bandy with being a leader of organized crime, and with

BANDY IS CHARGED WITH PAYING PEOPLE TO STAGE AUTOMOBILE COLLISIONS IN ORDER TO OBTAIN PATIENTS FOR HIS NUMEROUS CHIROPRACTIC CLINICS.

conspiracy to commit racketeering and health care claims fraud. Bandy is charged with paying people to stage automobile collisions in order to obtain patients for his numerous chiropractic clinics, and thereby generate billings under the Personal Injury Protection (PIP) portion of automobile insurance policies. ***Alejandro Ventura*** is charged with conspiracy to commit racketeering and health care claims fraud for arranging the automobile collisions and recruiting the participants. The remaining ten defendants are all charged with conspiracy to commit health care claims fraud for their respective roles in participating in staged accidents which resulted in fraudulent billings being submitted to various insurance carriers. ***Victor Almonte*** is charged with participating in a staged accident on July 15, 1998, which resulted in more than $35,000 in false PIP billings. ***Josue Cespedes*** is charged with participating in a staged accident on September 9, 1998, which resulted in more than $32,000 in false PIP billings. Four defendants are charged with participating in a staged accident on March 31, 1999, which resulted in $33,594 in false PIP billings. The remaining four defendants are charged with participating in a staged accident on April 23, 1999, which resulted in more than $6,000 in false PIP billings. This case is the first organized fraud ring penetrated by undercover investigators from OIFP and the first organized automobile insurance fraud ring prosecuted under the tough new Health Care Claims Fraud statute, *N.J.S.A.* 2C:21-4.3. OIFP views this type of case as particularly important, not merely because of its economic effect, but, even more significantly, because of the consequent threat to public safety presented when accidents are intentionally caused on our roadways. The investigation is continuing.

Fake Accidents

State v. Phillip Major. On September 29, 1999, former East Orange police officer Major pleaded guilty to official misconduct and conspiracy to commit theft, bribery, falsifying records and official misconduct. Major admitted that he wrote 16 motor vehicle accident reports for accidents which had not occurred. The false police reports were used to support 60 fraudulent insurance claims made to 11 insurance carriers and totaling more than $900,000 in PIP and property damage claims and bodily injury lawsuit settlements. Major also admitted to being a "runner" for two northern New Jersey chiropractors. Major, facing a possible sentence of ten years in prison, has agreed to cooperate in the investigation of others involved in the scheme and the investigation is ongoing. The involvement of law enforcement officers in criminal conduct undermines public confidence and cannot be reconciled with a government of laws. Accordingly, OIFP emphasizes the need for aggressive prosecution where law enforcement personnel are found to have violated the criminal law.

THE INVOLVEMENT OF LAW ENFORCEMENT OFFICERS IN CRIMINAL CONDUCT CANNOT BE RECONCILED WITH A GOVERNMENT OF LAWS.

"Give-Up" Schemes

State v. Francisca Ionescu and ***State v. Michael Garry***. On December 10, 1999, the State Grand Jury returned indictments in two unrelated cases involving automobile "give up" insurance fraud schemes. According to the first indictment, Ionescu conspired with a person known only as "Mike" to get rid of her 1997 Honda, gave the car to Mike and then falsely reported to police that it had been stolen. Thereafter, Ionescu falsely completed an Affidavit of Vehicle Theft and submitted it to her automobile insurer to obtain approximately $12,000. The second indictment charges that Garry conspired with a man known only as "A.J." to get rid of his 1996 Pathfinder. After giving his car to A.J., Garry reported it stolen to West New York police and

thereafter filed a false automobile insurance theft claim seeking almost $28,000 for the value of the vehicle. The cases were investigated by OIFP based on information received, respectively, from the North Carolina Division of Motor Vehicles and the United States Secret Service.

State v. Frank Papandrea. In October 1999, attorneys in the Division of Law obtained a stipulation of settlement from Papandrea imposing a civil monetary penalty of $7,500. Papandrea reported his automobile stolen and filed theft claims under his automobile and his homeowners' insurance policies alleging that personal items had been in the trunk of the vehicle at the time of the theft. Subsequent to filing the false claims, Papandrea admitted that he had staged the theft of his vehicle.

Using "Runners"

State v. Robert Matturo, et al. On April 21, 1999, a State Grand Jury indicted two chiropractors and the operator of a physical therapy business located above one of the chiropractic offices for conspiracy, computer theft, official misconduct and bribery. The indictment alleges that the conspirators bribed a North Bergen Police Department Communications Supervisor to access the police computer to obtain internal documents known as accident current record reports and provide them to the conspirators. The indictment charges that Matturo and ***Nicholas Rosania***, co-owners of West New York Chiropractic Center, would then give the police accident information to "runners" for the purpose of soliciting the persons identified by the computer printouts to become patients.

THE INDICTMENT CHARGES THAT THE DEFENDANTS WOULD GIVE THE POLICE ACCIDENT INFORMATION TO RUNNERS.

State v. Cyrano Green, ***State v. James Lee Campbell*** and ***State v. Abigail Romero***. On April 21, 1999, the State Grand Jury returned three separate indictments charging Green, Campbell and Romero with having acted as "runners" and having independently given bribe money to an undercover police officer, whom they each believed to be a conspirator, in return for Newark Police Department automobile accident reports. The undercover police officer received 15 cash bribes totaling approximately $4,600 from the three runners. On November 29, 1999, Romero pleaded guilty to conspiracy and bribery, both second degree crimes, and admitted that she had acted as a "runner" who paid cash bribes to an undercover Newark police officer. In return, Romero received accident reports on 12 occasions. Although Romero had believed she was bribing the police officer, in reality the officer was posing as a corrupt officer as part of an undercover investigation conducted by the Newark Police Department and OIFP. On January 28, 2000, Romero was sentenced to a term of three years in jail. Because her sentence was not imposed in 1999, it is not, however, included in the jail time chart, *supra*, or in the statistics reported to the Legislature and Governor for calendar year 1999. The State elected to charge official bribery because the conduct occurred prior to the enactment of legislation criminalizing running. See *N.J.S.A.* 2C:21-22.1. OIFP anticipates that the new law criminalizing this conduct will provide leverage to obtain cooperation, so that doctors and lawyers who hire runners can be prosecuted.

ROMERO BELIEVED SHE WAS BRIBING A POLICE OFFICER; IN REALITY THE OFFICER WAS PART OF AN OIFP UNDERCOVER INVESTIGATION.

Phony Auto Insurance Documents

State v. Hani Elias. On August 20, 1999, Elias, who sold bogus automobile insurance cards despite having been ordered by a Superior Court judge to stop, began serving a 364 day jail sentence. Elias was additionally ordered to pay $1,500 in restitution to a consumer who had purchased a phony card from him. Elias is a former licensed insurance broker whose license was revoked in 1994. Despite this, Elias continued to sell auto insurance cards. In January 1998, Elias sold a fraudulent automobile insurance card to an undercover officer and, six months later, sold a fraudulent insurance card to a private citizen, thus bilking the consumer of his money while failing to provide automotive insurance coverage in return. The State initially proceeded civilly against Elias, obtaining an order from a Chancery Division judge requiring Elias to halt sale of auto insurance cards. When Elias disregarded the court order and continued to sell fraudulent insurance cards to unwitting consumers, he was criminally prosecuted by OIFP for contempt and other related crimes.

WHEN ELIAS SOLD FRAUDULENT INSURANCE CARDS TO UNWITTING CONSUMERS, HE WAS CRIMINALLY PROSECUTED BY OIFP.

PROPERTY INSURANCE FRAUD

State v. Jack Chesner. An effort to fraudulently cash in on accidental property damage earned Chesner a four year State prison sentence on December 7, 1999. Chesner had been indicted for second degree attempted theft by deception and falsifying records based on his purchase of property insurance with backdated checks and submission of insurance claims to the carrier after the property had been destroyed through an accidental explosion.

AN EFFORT TO FRAUDULENTLY CASH IN ON ACCIDENTAL PROPERTY DAMAGE EARNED CHESNER A FOUR YEAR STATE PRISON SENTENCE.

State v. James Freda, et al. In November 1999, Freda was ordered to pay a civil penalty of $3,082 and required to make full restitution of $1,418 to his insurance company for a false claim. The monies were received in January 2000. Freda and ***Mary Maloney*** had submitted a homeowners' claim for two sets of golf clubs which they alleged had been stolen from their rental car during a vacation. In support of their claims, both Freda and Maloney submitted to their respective insurance companies forged receipts which purported to document their purchase of the golf clubs. On November 8, 1999, Maloney, whose claim had not been honored, paid $4,500 in civil penalties.

AGENT FRAUD

State v. William Conyers, et al. On May 7, 1999, the owner of a Bergen County funeral home, three of his family members and an insurance agent formerly licensed in New Jersey were indicted for their role in an alleged conspiracy whereby members of the family tried to illegally obtain $125,000 in death benefits through bogus life insurance policies. It is alleged that Conyers obtained life insurance policies for persons facing terminal

illnesses who had sought prearrangement for funeral services with Conyers' business. According to the charges, after receiving information from Conyers that the people named as policyholders had pre-existing medical conditions which would disqualify them as insureds, the insurance agent wrote life insurance policies with various carriers for the benefit of the conspirators. This case is pending in court.

State v. Charlene Vaughan. On August 9, 1999, a former insurance adjuster was indicted on charges of defrauding her employer of more than $8,000 by having payments made to an outside consultant for fictitious services. The indictment alleges that between July 1996 and April 1998, in the course of her employment, Vaughan was able to request that checks be paid to a consultant for services rendered in reviewing workers' compensation files. In 42 instances, the outside consultant had not performed the services, but Vaughan obtained the checks, forged the consultant's signature and cashed the checks. On February 2, 2000, Vaughan entered a negotiated plea of guilty to third degree theft and agreed to make full restitution. Her sentencing is scheduled for April 14, 2000.

State v. Sharon DaCosta-Barrett, et al. On September 10, 1999, a former health insurance claims processor was sentenced to four years in State Prison for theft of almost $100,000 in phony claims. She created non-existent health care claims and used her position to foster the impression that insurance payments were due on the claims. DaCosta-Barrett then issued checks to her family members. The three family members were indicted on April 7, 1999, for theft and conspiracy. Of these latter defendants, ***Sharmaine Wilson*** pleaded guilty on December 17, 1999. Charges against the other two defendants are still pending. The theft was discovered during a random inspection by auditors from Blue Cross/Blue Shield and referred to OIFP.

DACOSTA BARRETT, A FORMER HEALTH INSURANCE CLAIMS PROCESSOR, WAS SENTENCED TO FOUR YEARS IN STATE PRISON.

State v. Gonzalo Pena, et al. On February 11, 1999, following a trial in Union County, a verdict was rendered in a civil prosecution in favor of the State against Pena and his insurance agent, ***Zoila Del Sol***, for providing false information to Allstate Insurance Company in order to obtain coverage for vandalism damage to Pena's automobile. Each defendant was adjudged liable for two separate violations of the Insurance Fraud Prevention Act, *N.J.S.A.* 17:33A-4, and was ordered to pay a civil penalty and attorneys' fees to the State.

In re Jean Marie Levin. In May 1999, Levin paid restitution to her former employer, an insurance company, of over $16,000. In addition, she paid a civil penalty of $15,000. Levin, a former employee of the GRE Insurance Company, admitted forging her supervisor's signature on claim payment request forms and endorsing and cashing the false claim payments to herself and her sister.

OTHER FRAUD BY LICENSED PROFESSIONALS

State v. Susan M. Malady, R.N. On November 5, 1999, Malady, who had been Director of Nursing at St. Claire's Hospital, Dover Campus, received a five year State prison sentence on charges of theft by deception, forgery and falsifying records, for submitting $97,400 in fraudulent expense vouchers to her employer. Malady used the proceeds of the theft for pleasure trips to Alaska and Florida, to pay credit card bills, and for installment payments in connection with her purchase of a Cessna airplane. As part of her sentence, Malady is required to make full restitution to the hospital and pay a $5,000 fine to the State. OIFP forwarded a record of her criminal conviction to the New Jersey Board of Nursing for appropriate professional licensing action.

State v. Salvatore DeLello, Jr., Esq. On August 10, 1999 DeLello, an attorney, pleaded guilty to charges of third degree commercial bribery and fourth degree forgery, falsifying records and false swearing based on his involvement in a multi-million dollar mortgage scam. DeLello's role in the fraud was revealed by his having falsely notarized documents on behalf of a fictitious person. At his sentencing on October 1, 1999, DeLello received probation and was required to pay the maximum criminal fine of $30,000. OIFP referred the matter to the Office of Attorney Ethics and DeLello has been disbarred.

LABOR FRAUD

Unemployment Insurance Fraud

State v. Lowenia Collins, State v. Keith Nelson, State v. David Harris. On May 24, 1999, as a result of a cooperative effort between OIFP, the Labor Prosecutions Unit of the Division of Criminal Justice and the New Jersey Department of Labor, three persons were separately indicted by a State Grand Jury for allegedly falsifying official documents in order to obtain thousands of dollars in unemployment insurance to which they were not entitled.

State v. William E. Williams, State v. Nelly Labrador, State v. Gerris Slaughter. On June 14, 1999, three indictments were returned separately charging three individuals with falsifying official documents in order to obtain thousands of dollars in unemployment insurance. It is alleged that each of the three sought and obtained unemployment compensation while they were currently employed. Williams received more than $20,000, Labrador almost $45,000 and Slaughter approximately $6,500. The investigation was conducted by the Division of Criminal Justice Labor Prosecutions Unit in conjunction with OIFP and the State Department of Labor.

Disability Insurance Fraud

State v. Jayen C. Shah, M.D. On January 7, 1999, Shah was sentenced to five years in prison on his guilty pleas to second degree attempted theft and third degree theft. Shah had taken out disability insurance policies which would have paid him over $5,000 per month. Thereafter, he falsely claimed to have been paralyzed in a bus accident. While pretending to be confined to a wheel chair in

order to collect insurance money, Shah, disguised in a wig and sunglasses, was filmed by representatives of New York Life Insurance Company walking to a restaurant. The insurer forwarded the film to the Division of Criminal Justice for investigation and prosecution. A law enforcement "sting" operation was set up, whereby Shah was lured back from India under the guise of receiving settlement money, and was arrested. In addition to his prison sentence, Shah paid full restitution to the defrauded carriers, repaid over $70,000 in undeserved disability payments to the Social Security Administration and paid a $45,000 civil penalty. Shah's medical license was revoked by the Board of Medical Examiners. On September 15, 1999, the Appellate Division heard and denied Shah's appeal of his sentence as excessive. This case is an example of the good results engendered by effective communication between industry and law enforcement concerning ongoing insurance fraud.

THE SHAH CASE IS AN EXAMPLE OF THE GOOD RESULTS ENGENDERED BY EFFECTIVE COMMUNICATION BETWEEN INDUSTRY AND LAW ENFORCEMENT.

State v. Daniel Leake. On October 10, 1999, a consent judgment was obtained by Division of Law attorneys in the amount of $50,000 against Leake in a civil insurance fraud case. Leake had collected disability benefits to which he was not entitled from his employer's disability insurance carrier.

Workers' Compensation Insurance Fraud

State v. Lawrence Ford, Sr. On June 14, 1999, the State Grand Jury returned an indictment charging Ford with theft by deception and forgery for allegedly cashing more than $150,000 worth of workers' compensation checks issued to his deceased father. Ford's father had legitimately received the benefit payments until his death in October 1989. Between October 1989 and November 1998, Ford allegedly cashed 217 checks totaling $152,781. This investigation was conducted by the Labor Prosecutions Unit of the Division of Criminal Justice in conjunction with OIFP and the State Department of Labor's Division of Workers' Compensation. The case was referred by the Division of Workers' Compensation after new computer technology designed to uncover workers' compensation fraud revealed potential fraud.

THE STATE GRAND JURY RETURNED AN INDICTMENT CHARGING FORD WITH CASHING MORE THAN $150,000 WORTH OF WORKERS' COMPENSATION CHECKS ISSUED TO HIS DECEASED FATHER.

OIFP - CRIMINAL

OIFP criminal investigations are conducted by State Investigators in the Division of Criminal Justice, Department of Law and Public Safety, who are assigned to OIFP. The criminal cases are prosecuted by deputy attorneys general in OIFP, also located within the Division of Criminal Justice. The attorneys and criminal investigators are grouped within squads in either the Insurance Fraud Unit or the Medicaid Fraud Unit of OIFP. Each unit is headed by a Supervising Deputy Attorney General, who reports directly to the Assistant Attorney General-in-Charge of OIFP - Criminal. The Supervising State Investigators within each unit report to a Deputy Chief Investigator. The Deputy Chief Investigator in charge of OIFP - Criminal is under the supervision of the Managing Deputy Chief Investigator, who oversees both criminal and civil OIFP investigations.

The types of insurance fraud cases handled by OIFP - Criminal during the past year are varied, but can be grouped into one of several major categories, generally relating to health insurance or automobile insurance policies. Health insurance fraud cases comprise a large portion of OIFP's criminal investigations. Health insurance claims fraud is committed when a person makes a false statement in a document used to determine whether monetary benefits are due, or the amount of such benefits, with regard to a health insurance claim. *See N.J.S.A.* 2C:21-4.2. Health care fraud can be committed by practitioners, such as chiropractors and doctors, or by individual patients. A doctor who knowingly submits bills for medical services that were not actually provided or who knowingly provides and bills for unnecessary and expensive medical procedures, is committing health care fraud. Similarly, a patient who knowingly submits falsified medical receipts or works with a provider to submit a false or inflated claim for a shared benefit, is committing health care fraud.

The United States General Accounting Office has estimated that fraud accounts for up to ten percent of the annual expenditure on health care in the United States. The direct effect of health care fraud is to increase the cost of health insurance premiums paid by consumers. Indirect effects may be that less money is available for medical research and that some providers put their personal criminal interests in obtaining additional money ahead of the real medical needs of some of their patients.

It should be noted that many false or inflated medical claims arise out of injuries allegedly sustained in automobile accidents and may also increase the cost of the PIP component of car

insurance. During the past year, OIFP has prosecuted individuals and practitioners for health care fraud, and has prosecuted persons for setting up phony clinics from which to generate fraudulent claims, so called "medical mills."

Among the crimes of most concern to OIFP, because of their potential effect on the safety of the public, are staged accidents. For this type of crime, participants plan and stage a motor vehicle collision, sometimes deliberately involving unsuspecting motorists in the "accident." Experience suggests that the participants may then collaborate with medical personnel, attorneys and repair facilities who inflate the degree of injury and damage resulting from the accidents. In staging collisions, the perpetrators may position conspirators nearby to serve as "witnesses" to the "improper" conduct of the innocent motorist. In some staged accident cases, the participants may have several identities, accompanied by the use of different social security numbers and drivers' licenses, in order to avoid alerting insurers or the government to the fact that the same persons are repeatedly collecting for injuries allegedly sustained in motor vehicle accidents. Staged collisions threaten the safety of the motoring public and are also an economic drain on honest policyholders, who ultimately pay for the cost of the fraud through increased insurance premiums.

STAGED ACCIDENTS ARE AMONG THE CRIMES OF MOST CONCERN TO OIFP, BECAUSE OF THEIR POTENTIAL EFFECT ON THE SAFETY OF THE PUBLIC.

Automobile "give up" schemes are another type of automobile insurance fraud prosecuted by OIFP. A "give up" is a phony automobile theft case, where the owner or lessee of a vehicle voluntarily turns it over (the "give up") to a middleman, who then disposes of the vehicle. "Give ups" are sometimes undertaken to terminate expensive lease arrangement by having the insurance company pay the leasing company the value of the vehicle, often with some of the insurance proceeds being paid directly to the individual who leased the vehicle. Where a person gives up a vehicle which he owns, the entire insurance proceeds will be paid to the owner. Cars obtained by middlemen in give up schemes may be shipped overseas for sale, sent to "chop shops" and disassembled for parts, or simply abandoned in a public place after the insurance company has

WHILE INVESTIGATING AUTO "GIVE UP" CASES, OIFP WORKS VERY CLOSELY WITH THE DIVISION OF STATE POLICE.

"purchased" the vehicle by paying the claim, usually following a period of approximately 30 days. Some vehicles may be arsoned for the insurance money. While investigating "give up" cases, OIFP works very closely with the Division of State Police.

Another type of insurance fraud cases prosecuted during 1999 is workers' compensation fraud. Workers' compensation fraud can consist of claims fraud, the most common type, premium fraud or medical provider fraud. Employers are required to provide workers' compensation insurance in case an employee is injured while working. The premiums due depend on the risk associated with a particular type of employment and an employer's loss experience. Employers can commit insurance fraud by falsely classifying the type of business undertaken as a less risky one, which is premium fraud. Claims made against the workers' compensation fund can increase the employer's insurance premium. A worker injured on the job is entitled to collect for his health care costs and lost wages. False or exaggerated claims of injury on the job can deplete the fund and increase the cost to businesses, which may ultimately pass the increased cost along to the public in the form of increased prices for consumer goods and services. OIFP works closely on these types of insurance fraud with both the Workers' Compensation Division of the Department of Labor and the Labor Prosecutions Unit of the Division of Criminal Justice.

A significant portion of OIFP's criminal prosecutions are cases of Medicaid fraud. The Medicaid program is designed to pay for certain medical needs of the disabled and the economically disadvantaged. Thus, Medicaid fraud may reduce the monies available to fund the program and, in essence, amounts to stealing from the poor. The Medicaid program is equally funded by federal and State tax dollars and is different in each state. In New Jersey, the State's share of Medicaid expenditures constitutes approximately 15% of the annual budget. During 1999, OIFP's Medicaid Fraud Unit policed approximately $5 billion in medical assistance payments.

OIFP's Medicaid Fraud Unit investigates and prosecutes health care providers who defraud the Medicaid program. Medicaid fraud occurs when a provider fraudulently receives medical assistance payments to which he is not entitled or in a greater amount than that to which he is entitled. A provider who knowingly makes a false representation in a claim for Medicaid benefits will have committed both Medicaid fraud and health care claims fraud.

The Medicaid program is unique in that it pays for non-emergency transportation for all Medicaid recipients. Historically, this has been an area prone to abuse, so that a large portion of

Medicaid fraud cases arise from the provision of invalid coach services, often by inflating the mileage reimbursement costs.

Insurance Fraud Unit

OIFP's criminal Insurance Fraud Unit is headed by a supervising deputy attorney general, to whom 22 deputy attorneys general report. The 22 deputy attorneys general, in turn, are broken down into five squads, with one deputy attorney general serving as the team leader on each squad. In addition, a deputy attorney general who has received designation by the Supreme Court as a Certified Criminal Trial Attorney has been named team leader for litigation. There are 57 State Investigators assigned to the Insurance Fraud Unit. As with the attorneys, the investigators are divided into five squads, with a Supervising State Investigator heading each squad of investigators. Those five Supervising State Investigators, in turn, report to a Deputy Chief Investigator who is in charge of criminal investigations on behalf of OIFP.

The north office, located in Whippany, houses squad one and squad two of both attorneys and State Investigators. The central office in Lawrenceville houses squads three and four of attorneys and investigators. A single squad, squad five, comprised of prosecuting attorneys and State Investigators, is housed in the Cherry Hill south office.

Three analysts are assigned to the Insurance Fraud Unit to offer assistance in organizing and analyzing documents and other insurance claims-related data obtained during the course of investigations. The senior analyst supervises the other two analysts, as well as several technical assistants who support the analytical function.

Medicaid Fraud Unit

A supervising deputy attorney general leads the Medicaid Fraud Unit, which is comprised of six other attorneys and 16 State Investigators. The Medicaid Fraud Unit is centrally housed in the Lawrenceville office of OIFP, where eight investigators and five attorneys are assigned. It also maintains a presence in the north office, to which two attorneys and eight criminal investigators are assigned. The north and central squads of investigators are each headed by a Supervising State Investigator, who also report to the Deputy Chief Investigator in charge of criminal investigations.

In addition, an auditor, a paralegal and a management information systems specialist assist in financial analysis, legal research and case tracking for the Medicaid Fraud Unit. Additional auditors are in the process of being hired.

In addition to prosecuting provider fraud, the Medicaid Fraud Unit is also charged with investigating fraud in the administration of the Medicaid program. The Unit also cooperates with federal investigators and prosecutors to coordinate investigations and prosecutions involving the same suspects or allegations.

The Unit is intended to operate using a "strike force" concept of attorneys, auditors and investigators working together full time to develop Medicaid fraud investigations and prosecutions. The staff of the Unit includes attorneys experienced in the investigation and prosecution of civil fraud and criminal cases, auditors capable of reviewing financial records and State Investigators with experience in white collar crime investigations.

Criminal Investigation and Prosecution Statistics

At the conclusion of 1998, OIFP - Criminal had 138 open cases, involving 557 subjects. During 1999, OIFP opened 344 new criminal cases, involving 713 subjects, and charged 134 persons by indictment or accusation. Accordingly, during 1999 OIFP - Criminal conducted investigations of 1,270 persons. OIFP prosecutors obtained 78 criminal convictions during the year, with these defendants being ordered to pay more than $1 million in criminal fines and more than $5 million as restitution.

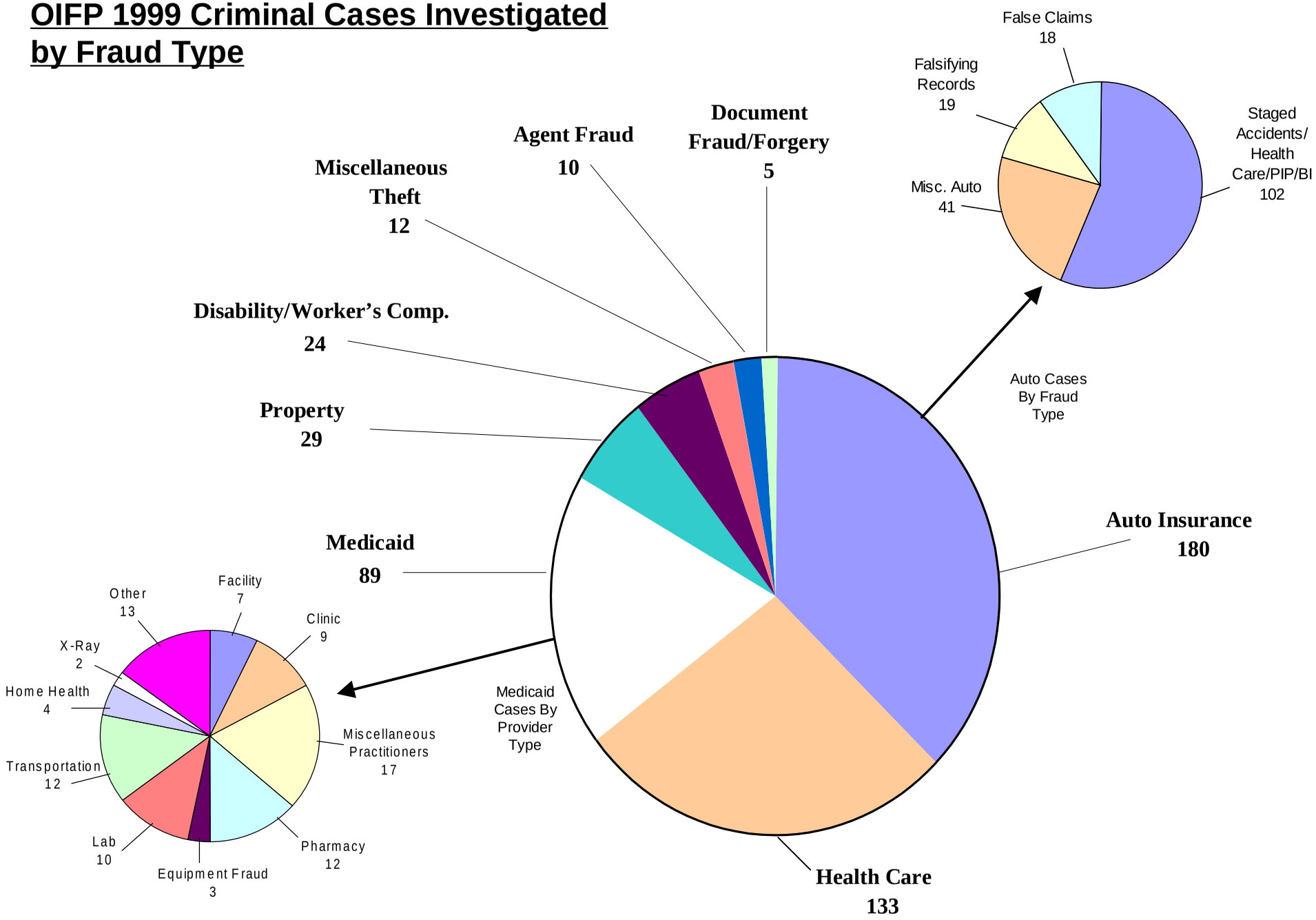
OIFP PROSECUTORS OBTAINED 78 CRIMINAL CONVICTIONS DURING THE YEAR, WITH THESE DEFENDANTS BEING ORDERED TO PAY MORE THAN $1 MILLION IN CRIMINAL FINES AND MORE THAN $5 MILLION AS RESTITUTION.

OIFP Criminal Statistics Summary

January 1, 1999 - December 31, 1999

Cases Pending at end of 1998	**138**
Individual Subjects of Pending Cases	**557**
New Cases Opened	**344**
Individual Subjects of New Cases	**713**
Cases Investigated (pending plus opened during period)	**482**
Persons Investigated	**1,270**
Subjects Prosecuted (Indictments/Accusations)	**134**
Convictions (Pleas/Trial Convictions)	**78**
Total Fines	**$1,108,621**
Total Restitution	**$5,286,576**

OIFP 1999 Criminal Cases Investigated by Fraud Type



OIFP - CIVIL

OIFP civil cases are investigated by civil investigators in the Division of Criminal Justice, Department of Law and Public Safety. Civil cases are litigated by deputy attorneys general in the Division of Law's Insurance Fraud Unit. These attorneys are located in OIFP's central office in Lawrenceville.

An effective enforcement scheme consists of both criminal and civil prosecution of fraud. Civil insurance fraud occurs when a person violates the New Jersey Insurance Fraud Prevention Act (Fraud Act), *N.J.S.A.* 17:33A-4. That statute provides that a person or practitioner commits civil insurance fraud by, among other enumerated conduct, submitting a false statement in support of a claim for benefits from an insurer, or in submitting a false statement or making a material omission on an application for insurance.

AN EFFECTIVE ENFORCEMENT SCHEME CONSISTS OF BOTH CRIMINAL AND CIVIL PROSECUTION OF FRAUD.

The civil Insurance Fraud Unit handles a variety of cases relating to application and claims fraud, the majority of which involve automobile, homeowners and health and disability insurance. Examples of automobile application fraud handled by the Insurance Fraud Unit include use of a New Jersey address by an out-of-state resident to obtain cheaper insurance, a practice known as "rate evasion," or the omission of information involving motor vehicle violations or accidents on an application for automobile insurance resulting in a lower premium. Examples of health insurance application fraud include the representation that individuals listed on a health insurance application are family members or are full-time employees of an insured entity when they are not, which is known as seeking coverage for ineligible subscribers.

The types of claims fraud handled by the Insurance Fraud Unit fall into a wide array of categories. Examples of homeowners' property fraud include arson, staged losses where the insured purposely damages the insured premises or reports a phony burglary, inflated claims arising out of legitimate losses or claims involving the submission of false receipts. Homeowners' fraud may also involve false allegations of personal injury occurring at the insured premises. Automobile insurance fraud cases handled by the Unit involve a variety of conduct from property damage to personal injury claims. Cases handled in the past year include staged vehicle thefts, inflated or falsified claims for

property damage or the attempt to obtain personal injury protection (PIP) benefits from accidents in which the individual was not involved, a practice known as "jumping in." Some types of health or disability insurance fraud handled include allegations of patients submitting inflated claims to the insurance company for medical services, of persons who are collecting disability while simultaneously maintaining employment at a second job and of persons falsifying or exaggerating injuries sustained at work.

While a jail sentence cannot be imposed as the result of a civil insurance fraud case, the Fraud Act does provide for a stiff civil monetary penalty for each act of insurance fraud. For a first offense, the civil fine can be as much as $5,000. It increases to a maximum of $10,000 for the second offense and $15,000 for each subsequent offense. Significantly, each false statement or omission submitted in support of a claim constitutes a separate violation of the Fraud Act, thereby exposing a transgressor to enhanced penalties for multiple false statements or omissions made in the course of one claim. Although most acts of civil insurance fraud could also constitute a crime, such as the crime of falsification of records, *N.J.S.A.* 2C:21-4, in many instances it may be advantageous for the State to proceed only civilly as the best allocation of prosecutorial resources. For example, the State may elect to proceed civilly against a defendant who commits a small monetary fraud and will make full restitution. Furthermore, OIFP's efforts to combat insurance fraud is greatly enhanced by taking full advantage of the lower burden of proof requirements for civil (as opposed to criminal) insurance fraud cases. The Insurance Fraud Unit not only pursues civil penalties, but also seeks restitution and reimbursement of attorneys' fees, where appropriate.

THE INSURANCE FRAUD PREVENTION ACT PROVIDES FOR A STIFF CIVIL MONETARY PENALTY FOR EACH ACT OF INSURANCE FRAUD.

These civil matters are normally referred to OIFP by insurance companies when they suspect a fraud has occurred. Referrals also come into the civil intake unit through various other sources, such as other law enforcement or administrative agencies, "hot line" calls, online submissions to the OIFP web page and other private citizen complaints.

Civil Investigations

Organization

Civil investigations are the responsibility of the 120 investigators assigned to OIFP - Civil. Civil investigators are divided into North, Central and South Units. A Supervising State Investigator is in charge of each unit, and each unit in turn is broken down into four squads, with a team leader assigned to supervise each squad. The Supervising State Investigators report to a Deputy Chief Investigator in charge of civil investigations, who in turn is under the supervision of the Managing Deputy Chief Investigator. In this fashion, there are 42 investigators assigned to the North Unit, 38 investigators assigned to the Central Unit and 40 investigators in the South Unit.

Referrals

During 1999, OIFP received 13,921 referrals of suspected insurance fraud. Each referral is initially screened and many are accepted as potential civil cases, although some can be immediately identified as potential criminal matters. Of the referrals to OIFP, 6,483 were forwarded for investigation to civil OIFP investigators. Most of the remainder (7,438) of these referrals, primarily from the insurance industry, were lacking sufficient factual information to open an investigation and, accordingly, were administratively closed without investigative action. These referrals remain on file and, in the event further information is received or developed, may be reopened as investigations. In other referrals received by OIFP, it was determined that OIFP lacked jurisdiction and the matter was transferred by OIFP to the appropriate agency. In addition, 4,415 referrals which remained from previous years were opened for investigation during 1999. Members of the insurance industry were the primary source of the referrals received by OIFP, although citizen referrals, through the OIFP toll-free "hot line," were a significant secondary source, accounting for 1,253 referrals.

On numerous occasions during 1999, cases were initially investigated by civil OIFP investigators but were referred for criminal investigation based on the evidence initially obtained by civil investigators. In all of these matters, a distinct separation between civil and criminal investigations is maintained in cases involving parallel civil and criminal proceedings.

Generally, it is the civil investigative side of OIFP that develops cases and, if warranted, identifies activity which may be criminal and refers the case to OIFP - Criminal. Therefore, it is the

civil investigator's attention to detail that makes many criminal prosecutions possible. Many of the criminal successes were made possible by the invaluable assistance of OIFP - Civil.

Rate Evader Sweeps

During 1999, OIFP began a crackdown on automobile insurance rate evaders. The current sweep effort targeted both Pennsylvania and New York residents representing themselves as New Jersey drivers in order to obtain lower auto insurance rates.

In May 1999, teams of OIFP investigators surveilled highly populated areas of New York City, Staten Island and Philadelphia. A total of 2,565 vehicles with New Jersey registrations were observed to be garaged in these out-of-state locations. Although rate evader sweeps initially produce thousands of *suspected* rate evaders, the *actual* number of violations is generally comparatively small. Investigation and prosecution of rate evaders requires a substantial commitment of time and resources to produce accurate and valid results, because of the labor intensive inquiry involved in distinguishing between law breakers and those with justification for their New Jersey registrations. Anything less than a full commitment of necessary resources in this investigative effort could result in innocent persons being improperly accused of violating the law.

Observation of New Jersey license plates on cars parked overnight in residential areas of a neighboring state provides *prima facie* evidence that non-residents insure their vehicles through New Jersey-based insurance, but further investigation is necessary because the underlying facts may not constitute fraud. For example, a vehicle may be leased to an out-of-state resident by a New Jersey company and the owner, the leasing company which is based in New Jersey, registers its cars in this State. In another instance, a vehicle may be registered to a former New Jersey resident who has recently moved. The task of obtaining a new registration may be delayed because of other pressing matters or not addressed until the expiration date of the previous registration. Because a myriad of explanations other than insurance fraud may exist for garaging New Jersey registered vehicles at out-of-state locations, shortcuts in the inquiry process could result in wrongful accusations against legitimately insured drivers.

OIFP's check of DMV records regarding the ownership of the surveilled vehicles with New Jersey tags eliminated hundreds of vehicles from the original list of suspect registrations. The

records revealed, in some instances, that the vehicle owners had recently moved when observed by OIFP investigators. The DMV check demonstrated that these persons had since re-registered the vehicles with the other state's DMV using their new out-of-state address and had recently received new license plates. Others were eliminated when it was determined that the vehicles were registered to a business headquartered in this State.

Information is continuing to be compiled to determine the actual residency of the owners suspected of rate evading in New Jersey. Some investigations have resulted in a reasonable belief that the owner resides outside of this State. In these cases, the owner has been contacted and asked to provide information regarding residency. If proof of residency in New Jersey cannot be provided, the matters will be civilly prosecuted.

Dispositions

Civil investigators issued 579 consent orders or agreements through which $1,466,360 was imposed in civil insurance fraud fines. Of these, 209 matters, totaling $726,900, have been concluded through investigator action. The remainder of the consent agreements or orders remain pending.

In 1999, OIFP made several changes to the consent agreement forms previously used by the Department of Banking and Insurance civil investigators. Most importantly, each consent order now contains a concise recitation of the fraudulent acts committed by the defendant. These admissions enable the consent order to be used as an additional tool should enforcement litigation subsequently be necessary. Similarly, the consent orders for persons holding professional licenses now state that they may be used against the signer in any civil or administrative proceeding related to a violation of the Insurance Fraud Prevention Act, including license revocation and suspension actions. Each signer must also specifically consent to entry of the document as a final administrative order. Each of these modifications renders a civil consent order obtained by OIFP civil investigators a document which can support civil litigation and be used to establish a prior insurance fraud violation and, additionally, may assist an insurer in obtaining restitution.

EACH CONSENT ORDER NOW CONTAINS A CONCISE RECITATION OF THE FRAUDULENT ACTS COMMITTED BY THE DEFENDANT.

A recent amendment to the Penalty Enforcement Act, *N.J.S.A.* 2A:58-10 *et seq.*, will further

enhance OIFP's collection capabilities with respect to its civil orders. The amendment allows OIFP to docket its consent orders as judgments with the Superior Court. This will permit OIFP to immediately employ legal collection procedures appropriate to a judgment and to avoid resorting to more time-consuming steps to reduce the consent order to a judgment.

Civil Litigation

Organization

OIFP civil cases are handled by 13 deputy attorneys general in the Insurance Fraud Unit of the Division of Law. One of the attorneys is designated as the lead deputy, and is responsible for supervising the other 12 attorneys. These attorneys are now located in the central OIFP office in Lawrenceville, where they are available to offer immediate assistance to members of OIFP as civil legal issues arise and to consult as needed on civil investigations. The civil deputy attorneys general are assisted by six paralegals.

Referrals

A total of 1,355 matters were referred for litigation to Insurance Fraud Unit attorneys in the Division of Law from OIFP civil investigators. A significant portion of the litigation conducted by civil attorneys arises from delinquent settlements, including consent orders and agreements.

Dispositions

The civil attorneys obtained original judgments or settlements in 50 cases. OIFP civil attorneys obtained $367,621 in judgments or settlements and an additional $2,709,029 through enforcement actions. In addition, the State was awarded over $11,650 in attorneys' fees based on litigation by these Division of Law attorneys. The attorneys resolved a total of 1,148 matters, including enforcement actions on previous settlements.

THE OIFP CIVIL ATTORNEYS RESOLVED A TOTAL OF 1,148 MATTERS.

Licensing Action Referrals

OIFP refers some matters directly to the relevant professional board and others to the Enforcement Bureau in the Division of Consumer Affairs, which conducts its own investigations of licensed professionals. If a case involves insurance agents or public adjusters, OIFP refers the matter to the Department of Banking and Insurance, which is responsible for licensing such professionals. In this manner, during 1999, 91 cases were referred by OIFP for licensing actions. Disciplinary licensing actions were taken against 26 persons during the past year.

The following represents the action taken by each board identified:

Licensing Actions Taken During 1999					
	Suspension	**Revocation**	**Voluntary Surrender**	**Reprimand**	**TOTAL**
Chiropractors	**2**	**3**	**0**	**0**	**5**
Medical	**2**	**2**	**1**	**2**	**7**
Psychologists	**2**	**1**	**0**	**0**	**3**
Dental	**4**	**0**	**0**	**4**	**8**
Pharmacy	**1**	**0**	**0**	**0**	**1**
Physical Therapy	**0**	**1**	**0**	**0**	**1**
Social Worker	**0**	**1**	**0**	**0**	**1**
TOTALS	**11**	**8**	**1**	**6**	**26**

Collections

When civil matters are concluded through OIFP investigator action or through the efforts of OIFP's civil attorneys, payment is required to be made to the Department of Banking and Insurance. The Department of Banking and Insurance reports that the State received $5,841,533 in payments during 1999 and that it closed 887 OIFP accounts receivable as paid in full during the year.

CIVIL HIGHLIGHTS

- OIFP and the Department of Banking and Insurance (DOBI) adopted joint regulations governing, among other things, the submission of fraud detection and prevention plans to DOBI and the referral of suspected cases of fraud to OIFP by insurance carriers. The regulations were published in the New Jersey Register on February 7, 2000. In essence, these new regulations require insurance carriers to identify specific facts and circumstances and to develop some minimal corroborating evidence before referring a case to OIFP. It is intended that the new referral standards will result in a better caliber of industry referrals (*i.e.*, increasing the percentage of industry referrals that warrant investigation) and an OIFP civil caseload more manageable than the staggering caseload referrals of previous years, which did not always allow for the thorough review, investigation or analysis necessary to pursue litigation. OIFP has established a training schedule to educate industry on use of the new referral forms developed by OIFP.

- On November 15 through 18, 1999, 27 County Investigators from various prosecutors' offices throughout the State attended the Basic Insurance Fraud Training Program developed and sponsored by OIFP - Civil. County Prosecutors' Offices had requested assistance from OIFP in learning proactive approaches to developing insurance fraud cases.

- During 1999, two classes attended the standard course for civil investigators held at the Division of Criminal Justice Academy in Sea Girt. The four week course for civil investigators was developed by OIFP and includes such necessary training as interviewing techniques, report writing, investigative techniques, sources of information, rules of evidence, surveillance, computer fraud, development of informants, insurance terminology and auto and health insurance fundamentals.

- In coordination with OIFP, the Division of Law instituted collection proceedings on

approximately 1,500 delinquent civil settlements representing well over $3 million in previously uncollected penalties. As a result of this initiative, the Division of Law collected over $1 million in cash payments on these delinquent accounts.

- ***State v. Christine Tooker.*** On December 6, 1999, Tooker, an insurance agent, entered a consent order whereby she agreed to pay a civil penalty of $1,500 for violation of the Insurance Fraud Prevention Act. Tooker, despite being advised by an applicant for an automobile insurance policy that he had at least one accident which should be listed on his application, submitted the application to an insurance company without listing any automobile accidents. This case is representative of OIFP's efforts to reduce fraud and intentional false statements on applications for insurance policies.

OIFP Civil Statistics Summary

January 1, 1999 - December 31, 1999

CIVIL INVESTIGATIONS	Number	Dollar Amount
New Cases Opened	13,921	
Number Forwarded for Investigation	6,483	
No Investigation Warranted	7,438	
Backlog Cases Opened	4,415	
TOTAL CIVIL MATTERS INVESTIGATED	10,898	
PRE-LITIGATION DISPOSITIONS		
Consent Orders/Agreements Issued	579	$1,466,360
Consent Orders/Agreements Executed	209	$726,900
LITIGATION (Division of Law)		
Number of Referrals Received by Division of Law	1,355	
Number of Cases Resolved:	1,148	
Enforcement Actions by Division of Law	1,098	$2,709,029
Division of Law Original Settlements	50	$367,621
COLLECTIONS (Department of Banking and Insurance)*		
Number of OIFP Accounts Paid in Full	887	

*As reported to OIFP by DOBI

Law Enforcement

County Prosecutors' Offices

County Prosecutor Liaison

The support of County Prosecutors' Offices and the coordination of referrals, investigations and prosecutions among those offices and other law enforcement agencies, including OIFP, is a key element of the statewide strategy of criminal insurance fraud enforcement mapped by AICRA. AICRA requires, in particular, that OIFP establish a formal liaison with each County Prosecutor's Office in order to establish procedures for coordinating referrals of insurance fraud investigations and prosecutions, and for sharing insurance fraud information with County Prosecutors' Offices throughout the State.

In September 1999, a former County Prosecutor who had served as President of the County Prosecutors' Association of New Jersey was appointed as a deputy attorney general and formally designated to act on behalf of OIFP as the liaison with County Prosecutors. Throughout the last four months of 1999, the Prosecutor Liaison met with each of the County Prosecutors or their designees at their respective offices. The purpose of the meetings was to acquaint the County Prosecutors and those members of their staffs assigned to insurance fraud matters with the genesis, mission and mandate of OIFP, to establish an open line of communication with each office, to review relevant legislation, to ascertain county needs and concerns and to generally encourage and support their efforts to establish or expand insurance units.

OIFP'S PROSECUTOR LIAISON ESTABLISHED PROCEDURES FOR COORDINATING REFERRALS, INVESTIGATIONS AND PROSECUTIONS WITH THE COUNTY OFFICES.

In conjunction with this series of meetings, the Prosecutor Liaison established procedures for coordinating referrals, investigations and prosecutions with the county offices. OIFP expects to refer between 100 and 200 cases in the year 2000 to County Prosecutors' Offices participating in the

County Reimbursement Program. Matters referred to County Prosecutors' Offices from OIFP are in addition to those insurance fraud cases initiated by the counties.

County Reimbursement Program

AICRA also provides that OIFP may reimburse County Prosecutors' Offices for their work in investigating and prosecuting insurance fraud. *N.J.S.A.* 17:33A-28. During 1999, OIFP established a program to provide financial and technical support to County Prosecutors' Offices throughout the State. Under a two-year reimbursement program initiated in June 1999, 16 of the 21 counties are receiving a total of $5,000,000 in funding from the Attorney General's Office to initiate or expand prosecutors' efforts in attacking insurance fraud.

AN INTRODUCTORY FOUR-DAY INSURANCE FRAUD TRAINING PROGRAM FOR ASSISTANT PROSECUTORS AND COUNTY INVESTIGATIVE PERSONNEL WAS CONDUCTED IN NOVEMBER 1999.

In addition to equipment and investigative costs funded by OIFP, nine additional attorneys, 25 investigators and seven clerical positions in County Prosecutors' Offices have been funded through the reimbursement program. An introductory four-day insurance fraud training program for assistant prosecutors and county investigative personnel was conducted in November 1999. At the training, 15 of the counties receiving funding were represented, and training was provided to 18 detectives or investigators and eight assistant prosecutors.

COUNTY PROSECUTORS' OFFICES
INDIVIDUALS UNDER INVESTIGATION IN 1999
FOR SUSPECTED INSURANCE FRAUD

ATLANTIC	20	GLOUCESTER	15	OCEAN	11
BERGEN	10	HUDSON	142	PASSAIC	162
BURLINGTON	1	HUNTERDON	1	SALEM	1
CAMDEN	21	MERCER	4	SOMERSET	14
CAPE MAY	5	MIDDLESEX	3	SUSSEX	1
CUMBERLAND	1	MONMOUTH	28	UNION	2
ESSEX	NA*	MORRIS	13	WARREN	4

*NA indicates that the total number of insurance fraud cases in this county were not available or not reported to OIFP.

Hudson County Prosecutor's Office

- ***State v. Juan Carlos Carmona, et al.*** On June 4, 1999, Carmona, the leader of a staged accident ring involving 94 defendants and $3 million in fraudulent claims, was sentenced to serve nine years in prison on five counts of conspiracy to commit theft by deception. At the entry of his guilty plea on March 25, 1999, Carmona also executed a $60,000 OIFP civil consent order. Accidents with commuter vans were either staged or fabricated and participants in the ring would falsely claim to have been injured as passengers. By the end of 1999, over five dozen of the other participants in the ring had either been convicted or pled guilty for their roles in the scam, which is one of the largest ever successfully investigated and prosecuted in New Jersey. In addition to the criminal charges, during 1999, four coconspirators with Carmona executed consent orders of between $2,000 and $2,500. On July 13, 1999, a Hudson County Grand Jury indicted another ten individuals in conjunction with claims for personal injury in an accident that never occurred.

- Since establishment of its Insurance Fraud Unit in 1999, the Hudson County Prosecutor's Office has opened an additional 27 files and participated in the arrest of 26 individuals on insurance fraud related matters. One defendant has been indicted by a State Grand Jury and 17 have been indicted by grand jurors in Hudson County. In addition, seven individuals are awaiting grand jury action and one juvenile case is awaiting a Family Court hearing.

- The Hudson County Insurance Fraud Unit recovered vehicles valued at $95,000 as part of its investigation of a "chop shop" operation, and participated in an investigation involving counterfeit Division of Motor Vehicle licenses. In the latter matter, the Unit recovered another $120,000 in falsely registered leased vehicles and returned these vehicles to the leasing companies, saving the individual insurance carriers approximately $225,000 in claims.

Passaic County Prosecutor's Office

- ***State v. Jose Siri, et al.*** On December 16, 1999, a special Passaic County Grand Jury handed up a 25 count indictment charging 21 people with staging phony accidents and pursuing fraudulent claims for medical bills and damages for bodily injury. Siri, ***Pablo Camilo*** and ***Fabian Beato*** were charged as the alleged ringleaders who organized the accidents covered by the indictment. The staged accidents resulted in $149,000 in medical claims to several insurance carriers, of which $118,000 was paid prior to the discovery of the fraud. The investigation is continuing.

Camden County Prosecutor's Office

- ***State v. Howard Lazaroff, Esq.*** On December 20, 1999, former attorney Lazaroff entered a guilty plea to embezzling more than $200,000 of clients' personal injury settlement proceeds. As a consequence, Lazaroff surrendered his license to practice law.

- Since its inception in November 1999, the Camden County Prosecutor's Insurance Fraud Unit has opened 22 investigations, of which two had resulted in guilty pleas and two more had resulted in indictments, by the end of 1999.

Atlantic County Prosecutor's Office

- ***State v. Louise Miller, et al.*** On May 24, 1999, Miller was sentenced to five years probation and 270 days in the Atlantic County jail on her plea of guilty to a single count of arson for the purpose of collecting insurance. As a condition of probation, she was also required to pay $109,000 in restitution to the Ohio Casualty Insurance Group. In October 1995, Miller had enlisted her brother, ***David W. Clark***, to set fire to her Egg Harbor Township home in order to collect the proceeds of her insurance policy and pay off her mortgage. Defendant Clark set the fire and the insurance company paid off the mortgage pursuant to the policy. On April 23, 1999, Clark was sentenced to eight years in State Prison, with a three year parole ineligibility period, on his plea of guilty to a count of conspiracy to commit arson for hire. This indictment was the result of a cooperative investigation involving the Egg Harbor Township Police Department and the Arson Unit of the Atlantic County Prosecutor's Office.

Monmouth County Prosecutor's Office

- ***State v. John DeBroy, et al.*** On November 17, 1999, a Monmouth County Grand Jury handed up an indictment charging DeBroy and Allyn with theft by deception and conspiracy. DeBroy, while a claims adjuster for the Proformance Insurance Company in Freehold, is alleged to have fraudulently issued six purported settlement checks and mailed them to a post office box which he controlled. It is alleged that the checks were later cashed with the assistance of DeBroy's roommate, codefendant ***Jeffrey Allyn.*** The insurance company's total loss has exceeded $44,000.

Bergen County Prosecutor's Office

- ***State v. Eric Zayas***. On October 1, 1999, the Bergen County Prosecutor's newly established Insurance Fraud Unit charged Zayas with theft, attempted theft and falsification of 36 medical records in conjunction with the submission of allegedly fraudulent claims for medical benefits on behalf of his wife. The claimed benefits under Zayas' employer's self-insured medical benefits plan, administered by Prudential Insurance Company, totaled approximately $10,600 of which $3,600 was paid before the fraud was discovered.

Ocean County Prosecutor's Office

- ***State v. Gary Olson.*** On December 21, 1999, an Ocean County Grand Jury indicted Olson, a building contractor, d/b/a Framin' Machine, LLC, for theft by deception and falsifying documents. Olson allegedly submitted altered and fabricated invoices and other documents to State Farm Insurance Company to inflate construction permitting and other charges he incurred in constructing a new home for the insured.

State Police

Insurance Fraud Unit

OIFP provides funding for an Insurance Fraud Unit within the New Jersey State Police, consisting of one sergeant and five troopers. This unit became fully operational on January 16, 1999, and began conducting investigations in March. As of December 31, 1999, the unit has conducted 203 investigations with the arrest of 223 individuals. Twenty of these arrests were made as a result of outstanding warrants. In the remaining 203 arrests, there were 228 criminal charges filed, primarily for having fraudulent motor vehicle insurance cards in violation of *N.J.S.A.* 2C:21-3 (formerly *N.J.S.A.* 2C:21-2.1a). Most of those arrested, resided in Camden County (74) and Hudson County (47). In addition to the criminal charges filed, the troopers issued 331 motor vehicle summons. On numerous occasions, the Unit has also assisted OIFP personnel in executing search warrants.

OIFP PROVIDES FUNDING FOR AN INSURANCE FRAUD UNIT WITHIN THE NEW JERSEY STATE POLICE, CONSISTING OF ONE SERGEANT AND FIVE TROOPERS.

The State Police Insurance Fraud Unit is also very active in presenting training programs across the State. During the past year, this State Police unit conducted 25 insurance fraud seminars, instructing over 1,000 law enforcement personnel. The seminars were geared towards prosecutors, criminal justice investigators, and other local, county and state law enforcement personnel.

Auto Theft Unit

In addition to the New Jersey State Police Insurance Fraud Unit, OIFP has worked consistently throughout the past year with the NJSP Auto Theft Unit. In several cases, investigation of auto "give ups" were conducted and, in 1999, 14 persons were arrested or had warrants issued for their arrests. These investigations involve individuals who would sell their vehicles to a middleman who later resold the vehicles in New York. The vehicles were then falsely reported to various police departments and insurance carriers as having been stolen. The defendants pleaded guilty to these charges. Three of the defendants were a husband, wife and daughter in the same family.

In one of the cases being jointly investigated with the State Police, a cooperative effort was established with the Union County Prosecutor's Office, further enhancing the liaison function of OIFP in fostering working relationships between law enforcement agencies throughout the State.

This enhanced cooperative effort allows for more efficient and sophisticated prosecutions of large scale criminal operations. OIFP's close working relationship with the State Police Auto Theft Unit will lead to additional auto give up prosecutions in 2000.

Municipal Police

During 1999, OIFP reached out to municipal police departments, with the recognition that their officers are at the front line in detecting many types of insurance fraud and that their actions can strongly impact on the quality of ensuing investigations. OIFP has conducted, through its Law Enforcement Liaison, meetings of law enforcement personnel to maintain lines of communication and suggest avenues of training to aid local police in combating insurance fraud. In the past year, three such Law Enforcement Liaison Conferences were held, one in each region of the State -- north, central and south. Municipal police departments were well represented at each meeting. Almost 200 representatives of 130 police departments were in attendance at the meetings -- with 35 departments represented at the north region meeting, representatives of 65 local departments attending the central meeting, and 30 municipal police departments represented at the law enforcement liaison meeting held in the south region.

OIFP also completed a "roll call" video for the use of local police departments. The video indicates ways in which police officers can help combat auto insurance fraud stemming from motor vehicle accidents. For example, the video suggests that police officers at the scene list the identity of every person in the car at the time of the accident, request verification of identity, and cross out all blank lines on completed motor vehicle accident reports, because these simple procedures prevent "add on" or "jump in" occupants from later claiming they were injured in the accident. The video is designed to be played at roll call before the start of a shift, which has been determined to be an efficient manner of distributing information to police officers, without burdening already busy police schedules. The video will be distributed to police departments across the State during 2000.

OIFP COMPLETED A "ROLL CALL" VIDEO FOR THE USE OF LOCAL POLICE DEPARTMENTS.

During 1999, OIFP offered basic insurance fraud training to municipal police at various police academies, including, on June 25, at the Camden Police Academy, on October 26, at the Morris County Police Academy and, on October 29, at the Monmouth County Police Academy.

Other Law Enforcement

OIFP's efforts to establish or maintain effective communication and cooperation with other law enforcement agencies responsible for insurance fraud enforcement was apparent in a variety of outreach efforts, both within and outside of New Jersey. For example, OIFP representatives met regularly with the FBI Liaison Committee and with county law enforcement groups during the year.

Government

Coordination with New Jersey Agencies

Liaison and Continuing Communications Group

OIFP's Liaison and Continuing Communications Group, which was created on October 21, 1998, met on a monthly basis during 1999. The Liaison Group was established to maintain a master list of active civil and criminal cases under investigation by OIFP and the Division of Consumer Affairs Enforcement Bureau, which conducts all investigations for the professional and occupational boards. At each meeting, the participants discuss non-confidential aspects of pending cases. The meetings are regularly attended by OIFP's Liaison to Professional Boards, as well as by OIFP investigative personnel, representatives of the Enforcement Bureau and other representatives of the Attorney General's Office.

At the end of 1999, the Liaison Group's master list contained 306 active cases, a substantial increase from the 146 active cases at the beginning of the year. During 1999, 36 cases were removed either because the case was closed with no action or because final action had been taken against a professional licensee or entity. While OIFP - Civil presented 174 new cases to the master list, OIFP - Criminal provided 81 new cases and the Enforcement Bureau added 42 cases. The numbers of new cases reported exceed the number added to the master list because one of the groups opened an already existing case or provided additional information on a currently opened case -- demonstrating the need for, and the efficacy of, this coordinating committee. During calendar year 1999, a running list was maintained of those professional licensees who were disciplined by one of the Division of Consumer Affairs' professional or occupational boards.

Department of Banking and Insurance

In late 1999, OIFP, DOBI Enforcement Division and the Division of Law in the Department of Law and Public Safety established a liaison group. While OIFP may prosecute insurance agents or public adjusters for insurance fraud, DOBI is responsible for licensing these professionals. Recognizing a need for better coordination of investigations involving licensed insurance agents and public adjusters suspected of committing insurance fraud, this group now meets regularly. At the group's first formal meeting in November 1999, 22 cases of mutual interest to both OIFP and DOBI were identified and discussed.

Department of Labor

A protocol was developed for the referral of cases and exchange of information among the Labor Prosecutions Unit in the Division of Criminal Justice, OIFP and the Division of Workers' Compensation in the Department of Labor. The protocol ensures that all matters in which any indicia of criminality exist will be forwarded by the Department of Labor for prosecutorial review in a timely fashion. The protocol establishes a procedure to refer cases to the appropriate prosecuting agency, whether OIFP, the Labor Prosecutions Unit or a County Prosecutor's Office, and to advise the Department of Labor of the matter's status. This protocol ensures continuing communication among the agencies responsible for workers' compensation enforcement matters.

Interstate Insurance Fraud Coordination

Mid-Atlantic States Insurance Fraud Association (MASIFA)

On January 24, April 20 and September 21, 1999, representatives of OIFP and DOBI met with State and local law enforcement agencies from New York, Pennsylvania, Maryland, Delaware and Virginia as part of the Mid-Atlantic States Insurance Fraud Association. Each of the member state agencies has responsibility for civil and/or criminal insurance fraud enforcement. The purpose of the group is to share information about new insurance fraud schemes and trends, as well as information about specific cases and targets that have interstate ramifications.

State Fraud Directors' Conference

On October 20 through 22, 1999, senior OIFP staff members attended the State Fraud Directors Conference, a national organization of public agencies responsible for investigating and/or prosecuting insurance fraud. The attendees shared ideas to combat insurance fraud and established lines of communication to ensure cooperation among other states' anti-insurance fraud agencies and OIFP. The conference also led to sharing of information regarding an apparent interstate fraud network and the coordination of efforts to assist in apprehending perpetrators.

International Association of Chiefs of Police

In October, members of OIFP's executive staff were guest speakers at the International Association of Chiefs of Police annual conference. The IACP is the world's oldest and largest nonprofit membership organization of police executives, with over 16,000 members in over 95 different nations. IACP's leadership consists of the operating chief executives of international, federal, state and local agencies of all sizes. The seminar showcased investigative tactics, resources and technology in law enforcement. OIFP provided a four hour session entitled "Fraudsters and Money Men." The multimedia presentation focused on the innovative and proactive work being done by bringing together civil and criminal prosecutions, as well as through money laundering investigations and prosecutions.

National Association of Medicaid Fraud Control Units (NAMFCU)

NAMFCU provides a forum for nationwide sharing of information, including intelligence and training, concerning Medicaid matters. It fosters interstate cooperation on all issues affecting the prosecution of Medicaid fraud and is a coordination point for New Jersey's efforts, with the Department of Justice, in negotiating civil settlements against national providers. OIFP, through the Medicaid Fraud Unit, is an active participant in all global settlements by NAMFCU where a targeted provider does business with New Jersey Medicaid.

OIFP, THROUGH THE MEDICAID FRAUD UNIT, IS AN ACTIVE PARTICIPANT IN ALL GLOBAL SETTLEMENTS BY NAMFCU WHERE A TARGETED PROVIDER DOES BUSINESS WITH NEW JERSEY MEDICAID.

A representative of OIFP's Medicaid Fraud Unit conducted a presentation on Medicaid fraud and money laundering at the annual meeting of the National Association of Medicaid Fraud Control Units. In addition, an OIFP attorney, representing NAMFCU, testified before the House of Representatives, Committee on Commerce, Subcommittee on Oversight and Investigations, about Medicaid fraud and abuse.

Industry

In 1999, OIFP, through its Industry Liaison, developed a solid working relationship with the insurance industry, in large part by its demonstrated commitment to open and continuing communication. OIFP's Industry Liaison is a board member of the New Jersey Special Investigators Association and attends the monthly meetings of the Association. Recognizing that, where possible, cooperative efforts between law enforcement and industry may make both more effective in their respective fights against insurance fraud, OIFP conducted a series of formal and informal meetings with company representatives and trade groups through the year. In January and again in July, mini-summits were hosted by OIFP for Managers and Directors of industry's Special Investigators Units. These meetings were extremely successful in identifying areas of concern and ways to address these issues.

IN 1999, OIFP MADE A COMMITMENT TO OPEN AND CONTINUING COMMUNICATION WITH THE INSURANCE INDUSTRY.

In addition, OIFP conducted more than a dozen informal meetings with company and trade group representatives about cases and other matters of importance to those individuals. The relationship which has developed with regard to the respective challenges and limitations of OIFP and industry has served to relieve any misunderstandings which may have previously existed between industry and law enforcement.

In March 2000, OIFP will increase its commitment to ongoing communication by beginning a series of mini-summits every three months. It is anticipated that these mini-summits will produce dialog that will enable the participants to quickly identify and address otherwise recurring issues. OIFP intends to expand the slate of participants to include other areas of State government involved

in the investigation of insurance fraud. With research and thoughtful deliberation of issues, it is the goal of OIFP to develop even more efficient approaches to identify emerging trends, set priorities for important investigative matters and improve the effectiveness of prosecutions of insurance fraud.

Industry Liaison Efforts

- On October 12, at the New Jersey Special Investigators Association (NJSIA) annual conference, OIFP, the Insurance Council of New Jersey and the NJSIA jointly sponsored a summit for industry executives and OIFP executive personnel. This summit focused attention on OIFP's successes and a wide range of statewide issues that are of concern to industry.

- On October 13, OIFP conducted a workshop for insurance industry representatives at the NJSIA annual conference regarding the proper reporting of cases of suspected insurance fraud to OIFP.

- In October, an OIFP representative attended the Marine Index Bureau's Claims Managers' Roundtable to speak with claims managers and attorneys representing employers in the maritime industry in New Jersey.

- On September 22, an OIFP representative spoke to the Garden State Automotive Federation, a group of owners of licensed auto body repair facilities in New Jersey with approximately 200 members, regarding OIFP, AICRA and insurance fraud affecting the auto repair industry.

- In November, attorneys from OIFP met with members of the New Jersey Society of Medical Assistants, including office managers, billing personnel, nurses and technicians, about OIFP, the Health Care Claims Fraud Act and health insurance fraud.

- On October 7, OIFP's Industry Liaison met with the Insurance Services Organization, National Claims Managers' Advisory Council.

- On May 11, OIFP participated in a Directors' Roundtable with representatives of New York, Pennsylvania and Massachusetts at the International Association of Auto Theft Investigators, Northeast Chapter meeting.

- On December 1, OIFP representatives spoke with members of industry regarding the regulatory changes in the industry fraud reporting requirements.

- Industry representatives were also instrumental in providing specific training to OIFP investigative personnel. For example, on April 1, Delta Dental presented training in dental fraud to OIFP investigators. On June 18 and June 23, Blue Cross/Blue Shield provided claims processing training to OIFP investigators. In July, the Anti-Fraud Association of the Northeast provided insurance fraud training to OIFP investigators. On September 16, Allstate Insurance provided training to OIFP on auto theft fraud. On July 22 and 23, Prudential P&C, Allstate NJ, State Farm and First Trenton Indemnity provided comprehensive training on all aspects of an automobile insurance policy for 70 new OIFP civil and criminal investigators. And, on October 6, the National Insurance Crime Bureau provided training to OIFP on legal issues involved in fighting insurance fraud.

DEVELOPMENT OF THE OFFICE

Regionalization of Offices

During the past year, three new offices housing OIFP and other employees of the Division of Criminal Justice were opened. The three new regional offices, in the north (Whippany), central (Lawrenceville) and south (Cherry Hill) areas of the State, allow OIFP to maintain a state-wide enforcement presence, better address local insurance fraud issues and more readily coordinate investigations with county and local law enforcement agencies.

Computer Enhancement

Case Management and Tracking

During the year, the Department of Law and Public Safety contracted with a software company to develop an integrated case tracking system. The ability to refer to one source for past and present case information will be a valuable and time-saving asset to OIFP. The chosen vendor has offered a similar product to effect case tracking and management to the legal community for a number of years. To assure that information on past cases and defendants is complete and that future case information is properly tracked, it is necessary to simultaneously include all case data from the Division of Criminal Justice.

In order to use previously recorded file data in the new system, it was necessary to convert the old case information into a format that could be recognized by the new system. The conversion of approximately 20 years of information was accomplished in the Fall of 1999. Concurrent with the data conversion, a second generation prototype of the system's "Intake Notebook" was developed to meet the intake information and data tracking requirements of OIFP's Analytical Case Tracking and Information Unit. Testing of the functionality of the initial phase of the project began in early 2000.

All Paid Claims Database

During the past year, OIFP conducted extensive research into the best approach to the significant undertaking of developing a database for all paid claims as required under the Automobile

Insurance Cost Reduction Act (AICRA), *N.J.S.A.* 17:33A-23. In June 1999, representatives from OIFP and the Department of Law and Public Safety met with representatives of the Automobile Insurance Bureau of Massachusetts (AIBM). AIBM has been operating an all claims database for auto injuries since 1993. It should be noted, however, that with 130,000 auto injury claims per year entered into their database, the Massachusetts database is small in comparison with New Jersey's projected 500,000 auto property damage, personal injury protection and bodily injury claims, which AICRA requires to be maintained in the planned database. This figure does not include the voluminous number of health care claims generated in New Jersey each year.

Based on knowledge gained from AIBM, OIFP hosted a series of meetings with information technology vendors who provide services ranging from database creation, high volume data transfer, data mining and data link/analysis. It is anticipated that in the coming year a database Project Administrator will be hired and OIFP will launch a database pilot project.

PUBLIC AWARENESS CAMPAIGN

During its first few months of operation, OIFP placed billboard ads in some of the more populated areas around the State advising the public of our toll free hotline number to report suspected insurance fraud. In October 1999, a $1.2 million public awareness campaign began, which features a series of television and radio spots with the theme "New Jersey's Fed Up" with insurance fraud. The ads prominently feature OIFP's toll free number for reporting insurance fraud and OIFP's website. In addition to the television and radio ads, ads on buses are appearing on six NJ Transit routes covering major cities and metropolitan areas in the State:

The objective of the public awareness campaign is twofold: to inform people that New Jersey's strategy of creating a single office with the sole mission of attacking fraud is working and to let people know that we want and need their help. In addition to the advertising, the campaign reaches out to the public to explain the issues involved in insurance fraud, including how the frauds are operated and how they cost each consumer. The second wave of ads began airing in February 2000.

THE OBJECTIVE OF THE PUBLIC AWARENESS CAMPAIGN IS TWOFOLD: TO INFORM PEOPLE THAT NEW JERSEY'S STRATEGY OF CREATING A SINGLE OFFICE WITH THE SOLE MISSION OF ATTACKING FRAUD IS WORKING AND TO LET PEOPLE KNOW THAT WE WANT AND NEED THEIR HELP.

RECOMMENDATIONS PURSUANT TO *N.J.S.A.* 17:33A-21

1. A State Police analysis of automobile insurance cards produced by motorists in the course of routine traffic stops indicates that as many as 20 percent or more of those cards fraudulently purport to provide insurance coverage where none exists. While some of these cards may have been legitimately manufactured and issued in the first instance (and the underlying insurance subsequently canceled for non-payment of premium), many of these cards are simply counterfeits of varying quality. As suggested by Gloucester County Prosecutor Andrew N. Yurick, the manufacture of counterfeit automobile insurance cards may largely be eliminated if the insurance industry were required to employ available anti-counterfeit technology such as a holographic image or other document security devices. This would be similar to the technology-based security features that will be utilized for New Jersey driver's licenses when the recently authorized ten-year driver's license is implemented. *N.J.S.A.* 39:3-10h requires that the material used for, and the manufacturing process of, the license prevent, to the extent possible, any alteration, delamination, duplication, counterfeiting, photographing, forging or other modification of the license. For an insurance identification card anti-counterfeiting program to be effective, security features would have to be of a uniform type and required of every carrier doing business in New Jersey.

2. In some states, auto insurers have access to information identifying all drivers residing at the same address as the applicant. This is a significant tool in combating false claims, because it allows the insurer to identify undisclosed drivers. The Division of Motor Vehicles' database was not designed to satisfy this special investigatory need of insurance companies. Thus, programming changes would be required at DMV (and perhaps with insurance companies) to permit DMV to provide this service to carriers electronically. OIFP recommends that DMV be given authority to charge carriers for the cost of the programming changes required to make this service available and that DMV be given authority to develop uniform criteria and formats for reporting addresses. OIFP is willing to set up a task force comprised of representatives from the Department of Law and Public Safety, DMV and industry to work on computer issues like this.

3. Present law (*N.J.S.A.* 45:9-13) prohibits the State Board of Medical Examiners from sharing information developed in the course of the board's investigations if an investigation results in a finding of no basis for disciplinary action. The only exception to this prohibition is where another agency obtains an order from the Superior Court allowing the disclosure. This restriction inhibits coordination of State investigations involving physicians. Whatever legitimate claims physicians may have to the confidentiality of a board investigation do not extend to other State agencies also empowered to investigate criminal or civil violations of law by doctors. Moreover, no other health professionals' investigations are accorded such a high degree of confidentiality. OIFP recommends that *N.J.S.A.* 45:9-19.3 be amended to permit the State Board of Medical Examiners to share investigative information with OIFP and other State agencies authorized to conduct investigations regarding the conduct of physicians. As a technical matter, a reference in current law to OIFP's predecessor agency should be updated.

4. OIFP recommends that a bill be enacted requiring insurance companies or other entities paying for medical services to send the patient a plain language statement of the services for which the insurance company or other paying entity was billed by a medical service provider. The patient is often the best source for reporting fraudulent billing activity by a medical service provider. Patients know when, where and what services were provided and by whom. However, unscrupulous providers often mask fraudulent activity and double billing by using complicated technical terms or billing codes in the bills they submit. The use of such complicated forms and terms prevents patients from acting as a check on such activity. If insurance companies and other entities paying for the services send the patient a statement describing each service in plain language and identifying the provider for each service, patients can more easily report instances of fraudulent billing.

5. A small number of unscrupulous health care professionals are responsible for a significant amount of fraudulent practices and billing to insurance companies. OIFP recommends that various provisions governing the ethical conduct of licensed health care practitioners, such as physicians, chiropractors, dentists, podiatrists and the like, be amended to require such

health care practitioners to notify the appropriate licensing authority if the practitioner is in possession of information which reasonably indicates that another practitioner has engaged in fraudulent conduct in connection with the rendition of, or billing for, health care services. Attorneys, through Rule of Professional Conduct 8.3, are already subject to disciplinary action if they fail to report ethical or legal violations by another attorney. This change would impose a similar ethical requirement on licensed health care practitioners. A practitioner who fails to notify the appropriate licensing authority would be subject to professional disciplinary action.

6. In order to further enhance OIFP's civil prosecution and penalty enforcement efforts, the OIFP recommends the following amendments to the Insurance Fraud Prevention Act, *N.J.S.A.* 17:33A-1, *et seq.*:

- Some have questioned whether fraudulent activity, which constitutes a violation of the Fraud Act when committed against private health insurance companies, violates the Act when committed against self insurers, such as the State Health Benefits Program. *N.J.S.A.* 17:33A-3 should be amended to eliminate any ambiguity that civil penalties and treble damages are available against those who defraud self insurers. Where a person commits insurance fraud against a self-insurer, it is illogical and impractical to require the State to elect between proceeding criminally or not at all. While this recommendation to include self-insurers for purposes of the Fraud Act has been previously considered, the consolidation of civil and criminal enforcement into one agency with a single funding source makes its reconsideration appropriate.

- A significant percentage of fraudulent claims is perpetrated by licensed professionals through business entities they own or control. OIFP recommends that *N.J.S.A.* 17:33A-4 be amended to establish a separate violation to pursue persons or practitioners who violate the Fraud Act through use of a business entity. The licensed professional would be responsible if fraudulent conduct is committed in the person or practitioner's name or the name of an entity owned in whole or in part by that person or practitioner and that person, practitioner or entity retained payments collected as a result of such conduct.

- To enhance civil penalty collection efforts, *N.J.S.A.* 17:33A-5 of the Fraud Act should be amended to permit the Attorney General to authorize any person to pay a civil penalty by the use of a credit card.

- A pattern of violations under the Fraud Act is defined as five or more related actions involving either the same victim or the same or similar actions on the part of the person or practitioner charged with violations. *N.J.S.A.* 17:33A-7 provides that an insurance company damaged as a result of a violation may sue for compensatory damages which may be trebled if the court determines that the defendant has engaged in a pattern of violating the Fraud Act. Practitioners may be involved in a pattern consisting of numerous violations. Therefore, the Fraud Act should be amended to require that a practitioner who has been found by a court to have committed a pattern of violations provide an accounting to the claimant under this section.

- *N.J.S.A.* 17:33A-11 should be amended to more clearly provide that insurance fraud investigative files are confidential and immune from discovery. The amendment is necessary to further OIFP's interest in protecting its informants, investigative techniques and other matters requiring confidentiality.

7. Since labor fraud prosecutions, particularly workers' compensation, disability and premium frauds, and securities fraud investigations of regulated brokers who are insurance agents, often fall within OIFP's statutory responsibility, and because the separation of fraud investigative skills and resources within the Division of Criminal Justice tends to diffuse and limit the Attorney General's overall effort to combat fraud, it is recommended that the above identified fraud units be consolidated within OIFP.